

Complete Summary

GUIDELINE TITLE

Referral guidelines for bowel cancer.

BIBLIOGRAPHIC SOURCE(S)

Association of Coloproctology of Great Britain and Ireland. Referral guidelines for bowel cancer. London (UK): Association of Coloproctology of Great Britain and Ireland; 2002 Apr 25. Various p. [356 references]

GUIDELINE STATUS

This is the current release of the guideline.

COMPLETE SUMMARY CONTENT

SCOPE
 METHODOLOGY - including Rating Scheme and Cost Analysis
 RECOMMENDATIONS
 EVIDENCE SUPPORTING THE RECOMMENDATIONS
 BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS
 QUALIFYING STATEMENTS
 IMPLEMENTATION OF THE GUIDELINE
 INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT
 CATEGORIES
 IDENTIFYING INFORMATION AND AVAILABILITY
 DISCLAIMER

SCOPE

DISEASE/CONDITION(S)

Bowel cancer (colorectal cancer)

GUIDELINE CATEGORY

Evaluation
 Management
 Risk Assessment

CLINICAL SPECIALTY

Colon and Rectal Surgery
 Family Practice
 Gastroenterology

Internal Medicine
Oncology
Preventive Medicine
Radiology

INTENDED USERS

Physicians

GUIDELINE OBJECTIVE(S)

- To help General Practitioners to select patients at higher risk of bowel cancer for prompt referral to hospital; specifically:
 - To identify 90% of patients with bowel cancer for prompt referral on the basis of the Government's "Two Week Standard"
 - To improve the management of patients with low risk symptoms so that the remaining 10% of cancer patients, who will continue to be diagnosed in normal clinics, do not suffer excessive delays

TARGET POPULATION

Patients at risk of bowel cancer

INTERVENTIONS AND PRACTICES CONSIDERED

Assessment

1. Risk stratification: age-based assessment of signs and symptoms indicating either high or low risk of bowel cancer
2. Physical exam
 - Rectal exam
 - Abdominal exam
3. Haemoglobin estimation
4. Assessment of family history, weight loss in the absence of other high-risk symptoms, and faecal occult blood (not recommended routinely because of low diagnostic value)

Management of Patients with Low Risk Symptoms

1. "Treat, watch-and-wait" strategy
2. Dietary measures
3. Anal hygiene for patients with symptoms of piles
4. Laxatives or stool softeners for patients with constipation
 - Ispaghula
 - Sterculia
 - Magnesium salts
 - Lactulose
5. Bowel sedatives for patients with loose stools
 - Loperamide hydrochloride
 - Diphenoxylate
6. Anti-spasmodics for patients with abdominal pain

7. Anal creams and suppositories
8. Management of iron deficiency anaemia
9. Patient education
10. Re-examination of persistent symptoms

Management of Patients with High Risk or Persistent Low-Risk Symptoms or Other Worrying Factors

1. Referral to hospital
 - Fast track two-week standard clinic
 - Routine appointment Normal Clinic (for persistent low-risk symptoms)
 - Urgent appointment Normal clinic (for low-risk patients with other worrying factors)

MAJOR OUTCOMES CONSIDERED

- Risks of investigations and interventions
- Diagnostic value of symptoms and symptom combinations
- Predictive value of symptoms and iron deficiency anaemia for bowel cancer
- Incidence and probability of bowel cancer
- Sensitivity and specificity of diagnostic tests
- Time between diagnosis and treatment of bowel cancer
- Effect of early and late diagnosis on stage of disease and outcome in patients with colorectal cancer
- 5-year survival

METHODOLOGY

METHODS USED TO COLLECT/SELECT EVIDENCE

Hand-searches of Published Literature (Primary Sources)
 Hand-searches of Published Literature (Secondary Sources)
 Searches of Electronic Databases

DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE

Search for Relevant Citations

The development of these referral guidelines has depended upon evidence from existing epidemiological studies, which can be divided into four sub-groups:

- Studies on the prevalence of the primary symptoms of bowel cancer and iron deficiency anaemia (IDA) in the community and primary care.
- Studies on the prevalence of the primary symptoms and IDA in patients with established bowel cancer.
- Studies on the predictive value of the primary symptoms and IDA for bowel cancer in the community, primary care, and hospital practice.
- Studies on the relationship between delay in treatment of bowel cancer and survival.

The following databases and Internet sites were searched for information:

- Medline 1990 -- (through PubMed at www.ncbi.nlm.nih.gov/entrez/)
- The Cochrane Library, which includes The Cochrane Database of Systematic Reviews, The Database of Abstracts Reviews of Effectiveness (DARE), The Cochrane Controlled Trials Register (CCTR/CENTRAL), and The Cochrane Review Methodology Database (CRMD) (<http://www.cochrane.org/index0.htm>)
- The National Guideline Clearinghouse (www.guideline.gov)
- The Canadian Medical Association, CPG Infobase (Clinical Practice Guidelines) (www.cma.ca/cpgs)
- The Scottish Intercollegiate Guidelines Network (SIGN) (www.sign.ac.uk/)
- The American Society of Colon and Rectal Surgeons (www.fascrs.org/)

Further citations were found through:

- The scanning of reference lists
- Consultation with other researchers and practitioners in the field
- The knowledge and experience of those involved with the guidelines

Due to time constraints a number of sources were not searched. This included such sources as EMBASE and the National Research Register (www.doh.gov.uk/research/nrr.htm), on the range of years covered, as in the case of Medline.

Medical subject headings (MeSH) and/or text words were used, and items were limited to English and human.

NUMBER OF SOURCE DOCUMENTS

Not stated

METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE

Weighting According to a Rating Scheme (Scheme Given)

RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE

Studies on the Epidemiology and Prevalence of Symptoms and Signs of Colorectal Cancer in the Community and Primary and Secondary Care (A Studies)

Level 1

- (i) At least 1,000 randomly selected subjects with numbers of exclusions
- (ii) Prospective and consecutive subjects
- (iii) Collection of data by administered questionnaires and/or diaries
- (iv) Should include definitions of:

- Change in bowel habit defined as:
 - Changes in frequency of defaecation
 - Changes in consistency of the stool
- Abdominal pain
- Iron deficiency anaemia
- Abdominal mass
 - Site
 - Certainty
- Rectal mass on rectal examination
 - Intraluminal or anorectal
 - Pelvic

NB Whichever is relevant to the study

Level 2: Meets 3 of the criteria

Level 3: Meets 2 of the criteria

Level 4: Meets 1 of the criteria

Studies on the Prevalence of Symptoms and Iron Deficiency Anaemia in Patients with Established Cancer (B Studies)

Level 1

(i) Total population with definition and numbers of exclusions

(ii) A prospective study

(iii) At least 400 consecutive patients

(iv) Only symptoms attributable to the cancer recorded

(v) Symptoms and signs recorded before diagnosis made

(vi) Anatomical site of the cancer recorded

(vii) All primary symptoms recorded

- Rectal bleeding
- Change in bowel habit
- Abdominal pain

(viii) Prevalence of symptom and sign combinations

(ix) Definition of the nature of the change in bowel habit

- Frequency of defaecation
- Consistency of the stools

(x) Characteristics of rectal bleeding including presence or absence of anal symptoms

(xi) Definition of abdominal pain

(xii) Definition and prevalence including level of iron deficiency anaemia

(xiii) Definition and prevalence of intestinal obstruction

(xiv) Date of onset, persistence or periodicity of the symptoms

(xv) All physical signs recorded

- Mass palpable on rectal examination
 - Intra-lumen
 - Anorectal
- Abdominal mass
 - Site
 - Certainty
- Signs of intestinal obstruction
 - Abdominal distension
 - Visible peristalsis

(xvi) Method of diagnosis

- By investigation
- By follow-up

Level 2: Meets at least 10 of the criteria

Level 3: Meets at least 7 of the criteria

Level 4: Meets at least 5 of the criteria

Level 5: Meets at least 3 of the criteria

Studies on the Predictive Value of Symptoms and Signs and an Iron Deficiency Anaemia for Bowel Cancer in the Community and Primary and Secondary Care (C Studies)

Level 1

(i) At least 500 randomly selected subjects with numbers of exclusions

(ii) Predictive value of combinations of symptoms as well as single symptoms and signs separately when relevant to the study

(iii) Prospective and consecutive subjects

(iv) Symptoms and signs recorded before diagnosis made

(v) Definitions of relevant symptom or diagnostic factor where relevant

- Change in bowel habit defined as:
 - Changes in frequency of defaecation
 - Changes in consistency of the stool
- Abdominal pain
- Iron deficiency anaemia including levels
- Intestinal obstruction
 - Abdominal distension
 - Visible peristalsis

(vi) Mode of diagnosis stated

(a) By investigation

(b) By follow-up

(vii) Anatomical site of the cancer recorded

Level 2: Meets 5 of the above criteria

Level 3: Meets 4 of the above criteria

Level 4: Meets 1 of the above criteria

Studies on the Effect of Early and Late Diagnosis on Stage of Disease and Outcome in Patients with Colorectal Cancer (D Studies)

Level 1

(i) Total population with definitions and numbers of exclusions

(ii) At least 500 consecutive cancer patients

(iii) Prospective

(iv) Definition of delay:

- Patient delay
- General Practitioner (GP) delay
- Hospital delay
 - Out-patient
 - Diagnosis
 - Treatment
- Total delay to treatment or decision not to treat

(v) Measurement of delay

- Mean
- Median
- % delay at 3 monthly intervals after the onset of symptoms

- (vi) Only symptoms attributable to the cancer recorded
- (vii) Symptoms and signs of the cancer recorded before diagnosis made and the date of onset of symptoms and of the detection of the physical sign
- (viii) Site of the cancer recorded
- (ix) Definition and nature of the symptoms and signs
- (x) Definition, presence and level of iron deficiency anaemia
- (xi) Definition and presence of intestinal obstruction
- (xi) Numbers diagnosed by screening
- (xiii) Mode of admission
 - Emergency
 - Elective
- (xiv) Mode of operation
 - Emergency
 - Elective
- (xv) Dukes' stage of disease recorded
- (xvi) Presence of liver metastases recorded
- (xvii) Curability of the tumour recorded with definitions of curative and palliative resections
- (xviii) 5 year survival recorded
- (xix) Mode of death defined
 - Crude death rates
 - Deaths due to cancer
- (xx) Causes of the delay

Level 2: Meets 12 of the criteria

Level 3: Meets 10 of the criteria

Level 4: Meets 7 of the criteria

Level 5: Meets 3 of the criteria

METHODS USED TO ANALYZE THE EVIDENCE

Systematic Review with Evidence Tables

DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE

Method of Assessment of the Quality of Evidence

The principles used for developing these guidelines, assigning levels of evidence to the relevant studies, and making graded recommendations were drawn from the Guidelines literature. The system chosen for the grading of the recommendations is similar to that used to grade recommendations on hypertension, thrombosis, and diabetes.

All studies reviewed within each of the four sub-groups were assigned a level of evidence based on the problem addressed and the design of the study.

Observations on the predictive value of symptoms for disease can be seriously biased by "selection phenomena." The selection bias may occur from the general population, via consultation behaviour, diagnostic and therapeutic activities of the General Practitioner, and by referral. It is important in advising the management of the primary symptoms of bowel cancer in primary care to take cognisance of the fact that the predictive value of these symptoms in this setting may be quite different to that in the community and in hospital practice. However as there have been few studies of this nature in primary care, these referral guidelines have also been based on hospital studies and on the common modes of presentation of patients with established cancer.

METHODS USED TO FORMULATE THE RECOMMENDATIONS

Expert Consensus

DESCRIPTION OF METHODS USED TO FORMULATE THE RECOMMENDATIONS

Drafting Committee and Wider Expert Advisory Groups

A seven member Drafting Committee was assembled (See Section titled "Expert Advisory Group" in the original guideline document); two General Practitioners, one Surgeon, one Physician, a Professor of Medical Education, an Epidemiologist and a patients' representative. The Drafting Committee then recruited a wider expert advisory group consisting of six General Practitioner (GP) representatives of the Royal College of General Practitioners, six representatives of the British Society of Gastroenterology, six representatives of the Association of Coloproctology of Great Britain and Ireland, one representative of the Royal College of Nursing, one of the Royal College of Physicians and one of the British Association of Surgical Oncology. There was a second larger informal group of reviewers, which was selected on the basis of declared interest in the referral guidelines (Listed in Appendix J original guideline document).

An initial draft was produced by the Drafting Committee and then circulated to the Expert Advisory Group and the wider group of reviewers.

RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS

Grading of the Recommendations

A - Strong evidence: Requires two Level 1 studies of the predictive value of symptoms and signs and/or an iron deficiency anaemia for cancer in primary care

B - Fairly strong evidence: Requires one Level 1 study in primary care and at least two Level 2 studies in primary care or hospital practice

C - Fairly weak evidence: Requires one Level 2 study in primary care or at least two Level 3 studies in primary care or hospital practice

D - Weaker evidence: Requires three Level 4 studies or evidence from expert committee reports or opinions and/or clinical experience of respected authorities

COST ANALYSIS

A formal cost analysis was not performed and published cost analyses were not reviewed.

METHOD OF GUIDELINE VALIDATION

External Peer Review
Internal Peer Review

DESCRIPTION OF METHOD OF GUIDELINE VALIDATION

An initial draft was produced by the Drafting Committee and then circulated to the Expert Advisory Group and the wider group of reviewers. The Drafting Committee discussed all reviewers' comments, and the final document was produced as a result of these reviewers' comments.

RECOMMENDATIONS

MAJOR RECOMMENDATIONS

The Levels of Evidence (1-5) and Scale Used for Evidence Grading (A--D) are defined at the end of the "Major Recommendations" field.

Higher Risk Criteria

It is recommended that these symptom combinations when occurring for the first time, not as a recurrent episode, and the other diagnostic factors should be used to identify patients for referral on the basis of the Government's new "Two Week Standard." They should identify up to 90% of patients with bowel cancer.

Age Threshold		Grading of the Recommendations and Key Citations
All ages	Rectal bleeding WITH a change in bowel habit to looser stools and/or frequency of defaecation persistent for 6 weeks	B (Metcalf et al., 1996; Fijten et al., 1995; Ellis, Jones, & Thompson, 1999; Norreland & Norreland, 1996)
Over 60 years	Change in bowel habit as above WITHOUT rectal bleeding and persistent for 6 weeks	C (Dodds & Thompson, 1999)
Over 60 years	Rectal bleeding persistently WITHOUT anal symptoms*	C (Ellis, Jones, & Thompson, 1999; Dodds & Thompson, 1999)
All ages	A definite palpable right-sided abdominal mass	D**
All ages	A definite palpable rectal mass (not pelvic)	D**
--	Iron deficiency anaemia WITHOUT an obvious cause below 10 Grams in post-menopausal women and below 11 Grams in all men	C (Cook et al., 1986; Calvey & Castleden, 1987; Rockey & Cello, 1993; Zuckerman & Benitez, 1992; McIntyre & Long, 1993; Kepczyk & Kadakia, 1995; Lucas, Logan, & Logan, 1996; Till & Grundman, 1997; Joosten et al., 1999)

* Anal symptoms include soreness, discomfort, itching, lumps, and prolapse, as well as pain

** Consensus of opinion

Low Risk Symptoms

It is recommended in patients having a normal abdominal and rectal examination and haemoglobin estimation that the following symptoms be used to identify patients at very low risk of bowel cancer.

- Rectal bleeding WITH anal symptoms
- Transient changes in bowel habit, particularly to harder stools and/or decreased frequency of defaecation
- Abdominal pain as a single symptom WITHOUT other high-risk symptoms and signs, an iron deficiency anaemia, or intestinal obstruction

Recurrent Symptoms over Prolonged Periods of Time

Patients with these symptoms can be initially safely managed by "treat, watch-and-wait" strategies for 3 months as described in the section below titled "Management of patients with low risk symptoms: 'Treat, watch-and-wait.'" However if symptoms persist or recur when off all treatment and:

- Remain low risk: refer to the normal clinic, where the patient will be seen routinely.

- Change to higher risk: refer on the basis of the "Two Week Standard," the fast track.
- Remain in the low risk category but are worrying or severe: refer for an urgent appointment in a routine clinic, the third alternative route for referral.

Factors of Little Diagnostic Value

Faecal occult bloods in symptomatic patients are of little value and should not be used.

Weight loss in the absence of higher risk symptoms unless rapid and profound

A positive family history does not sufficiently increase the risk of low-grade symptoms to merit urgent referral to the fast-track clinic.

The Third Alternative Route or Speed of Referral

It is crucially important that General Practitioners have the opportunity to arrange prompt Outpatient appointments for patients without higher risk symptoms. This will help avoid the temptation to make inappropriate referrals to the fast-track system. These patients should be accommodated by having an urgent appointment in a normal clinic, the third alternative route or speed of referral (see algorithm titled "The Three Alternative Speeds of Referral" in the original guideline document).

Management of Patients with Low Risk Symptoms: "Treat, Watch-and-Wait"

It is important to remember that at least 10% of patients with bowel cancer will present with low risk symptoms and these patients will continue to be diagnosed in routine clinics. Careful "treat, watch-and-wait" management strategies are needed to avoid excessive time lags before referral of these patients.

These strategies must be with the agreement of the patient, who will need to understand the overall benefit to all patients with these symptoms in avoiding unnecessary investigations. Patients who are not happy with this arrangement can be promptly referred to a normal clinic. Patients may be given written information about what constitutes higher risk symptoms so that they can self-refer back at any earlier stage if these develop as a part of "safety-netting." As described above, for anxious patients with low risk symptoms or persistent higher risk symptoms below the age thresholds, there is a third alternative route or speed of referral, an urgent appointment in a routine clinic. This mode of referral must be kept to a minimum however to ensure that all patients referred in this way are seen promptly.

After establishing that patients with low-risk symptoms do not have an abdominal and rectal mass and their haemoglobin is normal, patients should be advised about dietary measures or careful anal hygiene for those with the symptoms of piles. For patients with changes in bowel habit resistant to simple dietary treatment, this can be supplemented by laxatives or bowel sedatives. For constipation, mild laxatives such as Ispaghula and Sterculia should be tried first,

and then stool softeners, Magnesium salts or Lactulose. For patients with looser stools and/or increased frequency of defaecation, bowel sedatives such as Loperamide Hydrochloride or Diphenoxylate can be used. Treatment of abdominal pain can be supplemented by anti-spasmodics, and persistent anal symptoms by anal creams and suppositories. Patients should be told to report back to their GPs if symptoms return after stopping treatment.

Every patient with low risk symptoms successfully treated entirely in primary care may enable a patient with cancer to be seen and treated more quickly.

Management of Mild Iron Deficiency Anaemia

Although patients with a mild iron deficiency anaemia (IDA) (a haemoglobin above 10 Grams in post-menopausal women and above 11 Grams in all men) are not included in the higher risk criteria, these patients still need careful management. If there is no obvious cause for the IDA and the anaemia is resistant or recurs when treatment is stopped, they should all be referred for full investigation to either the fast-track or normal clinic depending of the level of the haemoglobin.

Management of Uncertain Abdominal and Rectal Masses

When abdominal or rectal masses may be due to faecal loading, the patient should be treated with laxatives and re-examined after 2 to 4 weeks.

Re-investigation of Patients with Recurrent or Persistent Symptoms

Both high quality barium enemas and colonoscopies can miss early cancers either as a result of perceptive errors or technical factors. The common failures occur in patients with severe sigmoid diverticular disease on barium enema examination and in incomplete examination to the caecum in patients having colonoscopy.

It is essential that colonoscopists examine the colon carefully both on insertion and withdrawal. This requires time and attention to detail.

It is important therefore that patients, particularly those with persistently higher risk symptoms should be rereferred. This however should be to a routine clinic, not on the basis of the "Two Week Standard."

Specimen Referral Proforma

A Specimen Referral proforma is shown in Appendix I of the original guideline document. This includes a list of all the higher risk symptom groups together with advice on the management of patients with low risk symptoms and the facility for urgent referral to a routine clinic when necessary, the third alternative route or speed of referral.

Definitions:

Levels of Evidence

Studies on the Epidemiology and Prevalence of Symptoms and Signs of Colorectal Cancer in the Community and Primary and Secondary Care (A Studies)

Level 1

- (i) At least 1000 randomly selected subjects with numbers of exclusions
- (ii) Prospective and consecutive subjects
- (iii) Collection of data by administered questionnaires and/or diaries
- (iv) Should include definitions of:
 - Change in bowel habit defined as:
 - Changes in frequency of defaecation
 - Changes in consistency of the stool
 - Abdominal pain
 - Iron deficiency anaemia
 - Abdominal mass
 - Site
 - Certainty
 - Rectal mass on rectal examination
 - Intralumen or anorectal
 - Pelvic

NB Whichever is relevant to the study

Level 2: Meets 3 of the criteria

Level 3: Meets 2 of the criteria

Level 4: Meets 1 of the criteria

Studies on the Prevalence of Symptoms and Iron Deficiency Anaemia in Patients with Established Cancer (B Studies)

Level 1

- (i) Total population with definition and numbers of exclusions
- (ii) A prospective study
- (iii) At least 400 consecutive patients
- (iv) Only symptoms attributable to the cancer recorded
- (v) Symptoms and signs recorded before diagnosis made
- (vi) Anatomical site of the cancer recorded

(vii) All primary symptoms recorded

- Rectal bleeding
- Change in bowel habit
- Abdominal pain

(viii) Prevalence of symptom and sign combinations

(ix) Definition of the nature of the change in bowel habit

- Frequency of defaecation
- Consistency of the stools

(x) Characteristics of rectal bleeding including presence or absence of anal symptoms

(xi) Definition of abdominal pain

(xii) Definition and prevalence including level of iron deficiency anaemia

(xiii) Definition and prevalence of intestinal obstruction

(xiv) Date of onset, persistence, or periodicity of the symptoms

(xv) All physical signs recorded

- Mass palpable on rectal examination
 - Intra-lumen
 - Anorectal
- Abdominal mass
 - Site
 - Certainty
- Signs of intestinal obstruction
 - Abdominal distension
 - Visible peristalsis

(xvi) Method of diagnosis

- By investigation
- By follow-up

Level 2: Meets at least 10 of the criteria

Level 3: Meets at least 7 of the criteria

Level 4: Meets at least 5 of the criteria

Level 5: Meets at least 3 of the criteria

Studies on the Predictive Value of Symptoms and Signs and an Iron Deficiency Anaemia for Bowel Cancer in the Community and Primary and Secondary Care (C Studies)

Level 1

- (i) At least 500 randomly selected subjects with numbers of exclusions
- (ii) Predictive value of combinations of symptoms as well as single symptoms and signs separately when relevant to the study
- (iii) Prospective and consecutive subjects
- (iv) Symptoms and signs recorded before diagnosis made
- (v) Definitions of relevant symptom or diagnostic factor where relevant
 - Change in bowel habit defined as:
 - Changes in frequency of defaecation
 - Changes in consistency of the stool
 - Abdominal pain
 - Iron deficiency anaemia including levels
 - Intestinal obstruction
 - Abdominal distension
 - Visible peristalsis
- (vi) Mode of diagnosis stated
 - (a) By investigation
 - (b) By follow-up
- (vii) Anatomical site of the cancer recorded

Level 2: Meets 5 of the above criteria

Level 3: Meets 4 of the above criteria

Level 4: Meets 1 of the above criteria

Studies on the Effect of Early and Late Diagnosis on Stage of Disease and Outcome in Patients with Colorectal Cancer (D Studies)

Level 1

- (i) Total population with definitions and numbers of exclusions
- (ii) At least 500 consecutive cancer patients
- (iii) Prospective

(iv) Definition of delay:

- Patient delay
- GP delay
- Hospital delay
 - Out-Patient
 - Diagnosis
 - Treatment
- Total delay to treatment or decision not to treat

(v) Measurement of delay

- Mean
- Median
- % delay at 3 monthly intervals after the onset of symptoms

(vi) Only symptoms attributable to the cancer recorded

(vii) Symptoms and signs of the cancer recorded before diagnosis made and the date of onset of symptoms and of the detection of the physical sign

(viii) Site of the cancer recorded

(ix) Definition and nature of the symptoms and signs

(x) Definition, presence and level of iron deficiency anaemia

(xi) Definition and presence of intestinal obstruction

(xi) Numbers diagnosed by screening

(xiii) Mode of admission

- Emergency
- Elective

(xiv) Mode of operation

- Emergency
- Elective

(xv) Dukes' stage of disease recorded

(xvi) Presence of liver metastases recorded

(xvii) Curability of the tumour recorded with definitions of curative and palliative resections

(xviii) 5 year survival recorded

(xix) Mode of death defined

- Crude death rates
- Deaths due to cancer

(xx) Causes of the delay

Level 2: Meets 12 of the criteria

Level 3: Meets 10 of the criteria

Level 4: Meets 7 of the criteria

Level 5: Meets 3 of the criteria

Recommendation Grades

A - Strong evidence: Requires two Level 1 studies of the predictive value of symptoms and signs and/or an iron deficiency anaemia for cancer in primary care

B - Fairly strong evidence: Requires one Level 1 study in primary care and at least two Level 2 studies in primary care or hospital practice

C - Fairly weak evidence: Requires one Level 2 study in primary care or at least two Level 3 studies in primary care or hospital practice

D - Weaker evidence: Requires three Level 4 studies or evidence from expert committee reports or opinions and/or clinical experience of respected authorities

CLINICAL ALGORITHM(S)

A clinical algorithm titled "The Three Alternative Speeds for Referral" is provided in the original guideline document.

EVIDENCE SUPPORTING THE RECOMMENDATIONS

REFERENCES SUPPORTING THE RECOMMENDATIONS

[References open in a new window](#)

TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

The type of supporting evidence is identified and graded for the recommendations concerning high-risk criteria for bowel cancer (see "Major Recommendations").

All of the reviewed studies were assigned a level of evidence based on the problem addressed and the design of the study (see Appendix A of the original guideline document).

BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

POTENTIAL BENEFITS

- The identification of patients at highest risk of cancer may help hospital practitioners identify those patients who will most benefit from flexible sigmoidoscopy and/or colonic imaging either by x-ray or colonoscopy.
- The Government's introduction of the 'Two Week Standard' for all patients suspected by their general practitioners of having cancer has focussed attention on the need for ensuring that the majority of patients with cancer are seen quickly and that limited resources are used in the most cost-effective way on those patients most likely to benefit.
- It is possible that the identification of symptom and sign combinations indicating higher and low risk of cancer and better management of an iron deficiency anaemia will significantly increase the effectiveness and efficiency of diagnosis of bowel cancer. This will greatly improve the quality of care of many cancer patients, and may increase the chance of survival of those who at present experience long delays before referral. The guidelines should also increase the quality of care of patients without cancer by safely avoiding the unnecessary worry of hospital referral and investigation.
- Every patient with low-risk symptoms successfully treated entirely in primary care may enable a patient with cancer to be seen and treated more quickly.

POTENTIAL HARMS

Not stated

QUALIFYING STATEMENTS

QUALIFYING STATEMENTS

The guidelines should not impose rigid constraints upon clinical practice. It will remain the responsibility of the General Practitioner to interpret their application, taking into account local circumstances and the needs and wishes of individual patients.

Time Constraints on the Development of the Guidelines

The Drafting Committee was asked to develop the Guidelines early in 1999 for dissemination in March 2000. The first meeting took place on the 11th May 1999 and there have been three subsequent meetings. Ideally all guidelines should be validated. Even the strongest recommendations based on firm evidence and sound judgements and implemented by targeted providers may not produce the intended changes in healthcare practice or outcomes. Ideally guidelines should not be released until at least some effort has been made to validate them. It is crucially important therefore that after the dissemination of these guidelines, prospective studies must be introduced to assess their validity. It is essential that future guidelines are more securely evidence-based on data from primary care.

DESCRIPTION OF IMPLEMENTATION STRATEGY

Background

The implementation of guidelines is complex and problematic. Merely devising accurate and up-to-date evidence-based guidelines, and even presenting them attractively, is unlikely to ensure they will be implemented. The conventional forms of continuing medical education (unsolicited written communication or oral communication through lectures) have been shown to be ineffective in changing doctors' practice.

General Practitioners (GPs) are a diverse group of doctors, whose response to implementation strategies is not uniform so multiple strategies are essential for a successful implementation.

The Nature of General Practice

Understanding how GPs practise shows how guidelines' implementation might best be approached. GPs must make a "judgement" about what is right in a particular situation. In the context of managing patients with the primary symptoms of bowel cancer, the probability of cancer is only one factor that contributes to that judgement.

As discussed previously, a "treat, watch-and-wait" strategy is appropriate for many presenting complaints, including the symptoms of bowel cancer, and this should be differentiated from the other sometimes used term, "wait-and-see," which suggests a less active process.

Specific Recommendations from the Literature on the Implementation of Guidelines

The following practical strategies have been shown to be effective and support previous theoretical analyses on professional judgement and decision-making by GPs.

- The development within a general practice of "an evaluative culture" including regular audit of practice and "critical incident" analysis
- Continuing education based on and reflecting the practice of GPs
- Peer review and group learning
- Personal education development plans that prompt GPs into seeing that they have a specific educational need, which they might not yet have recognised
- Organisational and management support is essential, involving consideration of work assignments, interactions between colleagues, feedback, and reward structure.
- The local development of guidelines (e.g., local groups developing their own guidelines [based on nationally agreed ones but incorporating local practice and conditions])
- Local outreach visits from opinion leaders
- Follow-up "re-education" at regular intervals to reinforce GPs' learning

- Personalised feedback (e.g., from a hospital specialist to a particular GP)
- Computer prompts during a GP's consultation with a patient

Local discussion about the implementation of the guidelines should not cease with agreement on the higher and low risk criteria but should include discussion of the methods of implementation as listed above.

Refer to Section 7 of the original guideline document for a discussion of the resources needed to achieve the "Two-Week Standard."

IMPLEMENTATION TOOLS

Chart Documentation/Checklists/Forms
Clinical Algorithm

For information about [availability](#), see the "Availability of Companion Documents" and "Patient Resources" fields below.

INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

IOM CARE NEED

Getting Better
Staying Healthy

IOM DOMAIN

Effectiveness
Patient-centeredness
Timeliness

IDENTIFYING INFORMATION AND AVAILABILITY

BIBLIOGRAPHIC SOURCE(S)

Association of Coloproctology of Great Britain and Ireland. Referral guidelines for bowel cancer. London (UK): Association of Coloproctology of Great Britain and Ireland; 2002 Apr 25. Various p. [356 references]

ADAPTATION

Not applicable: The guideline was not adapted from another source.

DATE RELEASED

2002 Apr 25

GUIDELINE DEVELOPER(S)

Association of Coloproctology of Britain and Ireland - Medical Specialty Society

SOURCE(S) OF FUNDING

Association of Coloproctology of Britain and Ireland

GUIDELINE COMMITTEE

Expert Advisory Group

COMPOSITION OF GROUP THAT AUTHORED THE GUIDELINE

Members: Mr M R Thompson (Chairman) (ACGBI) Portsmouth; Dr W S Atkin (ICRF, Epidemiologist) London; Professor C Coles (Education) Wessex; Dr B Ellis (RCGP) Petersfield; Ms L Faulds Wood (Patient Representative) London; Dr I Heath (RCGP) London; Dr E Swarbrick (BSG) Wolverhampton

FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST

Not stated

GUIDELINE STATUS

This is the current release of the guideline.

GUIDELINE AVAILABILITY

Electronic copies: Available in Portable Document Format (PDF) from the [Association of Coloproctology of Britain and Ireland Web site](#).

Print copies: Available from the Association of Coloproctology of Britain and Ireland at The Royal College of Surgeons of England, 35-43 Lincoln's Inn Fields, London, WC2A 3PE

AVAILABILITY OF COMPANION DOCUMENTS

The following is available:

- Specimen referral proforma. Appendix I. In: Referral guidelines for bowel cancer. London (UK): Association of Coloproctology of Great Britain and Ireland; 2002 Apr 25. Electronic copies: Available in Portable Document Format (PDF) from the [Association of Coloproctology of Britain and Ireland Web site](#).

Print copies: Available from the Association of Coloproctology of Britain and Ireland at The Royal College of Surgeons of England, 35-43 Lincoln's Inn Fields, London, WC2A 3PE

PATIENT RESOURCES

None available

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